		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037838

Facility Name: Oregon Healthcare Center

Address: 881 South 10th St. (Number) Oregon (City) 61061 (Zip Code)

County: Ogle

Telephone Number: (815) 732-7994 **Fax #** (815) 732-3733

IDPA ID Number: 363806980001

Date of Initial License for Current Owners: 03/01/1992

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-4580
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	38,064	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	38,064	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	615	14	2,223	2,852	8
9	SNF/PED					9
10	ICF	14,686	7,543	293	22,522	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,301	7,557	2,516	25,374	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 66.66%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 03/01/1992

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 03/01/1992 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1,607

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	188,495	6,372	1,273	196,140		196,140		196,140			1
2	Food Purchase		125,717		125,717		125,717	(3,921)	121,796			2
3	Housekeeping	128,261	33,703		161,964		161,964	(7,972)	153,992			3
4	Laundry	63,406	8,155		71,561		71,561		71,561			4
5	Heat and Other Utilities			82,070	82,070		82,070	1,289	83,359			5
6	Maintenance	70,282	26,276	4,255	100,813		100,813	366	101,179			6
7	Other (specify):*											7
8	**TOTAL General Services**	450,444	200,223	87,598	738,265		738,265	(10,238)	728,027			8
	B. Health Care and Programs											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	897,703	16,155	7,623	921,481		921,481	7,553	929,034			10
10a	Therapy			171,223	171,223		171,223		171,223			10a
11	Activities	51,252	5,358		56,610		56,610		56,610			11
12	Social Services											12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	948,955	21,513	182,446	1,152,914		1,152,914	7,553	1,160,467			16
	C. General Administration											
17	Administrative	36,116		205,550	241,666		241,666	(90,195)	151,471			17
18	Directors Fees											18
19	Professional Services			27,011	27,011		27,011	20,349	47,360			19
20	Dues, Fees, Subscriptions & Promotions			5,295	5,295		5,295	(141)	5,154			20
21	Clerical & General Office Expenses	128,146		34,343	162,489		162,489	50,166	212,655			21
22	Employee Benefits & Payroll Taxes			217,916	217,916		217,916	3,642	221,558			22
23	Inservice Training & Education											23
24	Travel and Seminar			597	597		597	54	651			24
25	Other Admin. Staff Transportation			5,947	5,947		5,947	184	6,131			25
26	Insurance-Prop.Liab.Malpractice			12,047	12,047		12,047	872	12,919			26
27	Other (specify):* Mgmt Co. Benefits							9,480	9,480			27
28	**TOTAL General Administration**	164,262		508,706	672,968		672,968	(5,589)	667,379			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,563,661	221,736	778,750	2,564,147		2,564,147	(8,274)	2,555,873			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Oregon Healthcare Center #0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			6,924	6,924		6,924	41,702	48,626			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,599	23,599		23,599	73,905	97,504			32
33	Real Estate Taxes			29,360	29,360		29,360	6,210	35,570			33
34	Rent-Facility & Grounds			341,640	341,640		341,640	(341,640)				34
35	Rent-Equipment & Vehicles			80	80		80	965	1,045			35
36	Other (specify):*											36
37	**TOTAL Ownership**			401,603	401,603		401,603	(218,858)	182,745			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		35,112	116	35,228		35,228		35,228			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			57,096	57,096		57,096		57,096			42
43	Other (specify):* Nonallowable Costs			30,915	30,915		30,915	(30,915)				43
44	**TOTAL Special Cost Centers**		35,112	88,127	123,239		123,239	(30,915)	92,324			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,563,661	256,848	1,268,480	3,088,989		3,088,989	(258,047)	2,830,942			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	7,213	30		9
10	Interest and Other Investment Income	(15,325)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(211)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(25,732)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,500)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(105)	43		24
25	Fund Raising, Advertising and Promotional	(75)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,891)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached PG5A	(4,484)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (44,110)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(213,937)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (213,937)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (258,047)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Oregon Healthcare Center

ID# 0037838

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Medicare lab expense	$ (2,458)	43	1
2	Medicare xray expense	(395)	43	2
3	Classified advertising	(1,439)	43	3
4	Trust fees	(500)	43	4
5	Disallow Chamber of Commerce dues	(206)	20	5
6	Unrealized gain/loss on partnership	514	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,484)		49

Oregon Healthcare Center
Provider #: 0037838
01/01/04 to 12/31/04 **Schedule 5A**

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oregon Healthcare Center # 0037838 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	31	(310)	0	0	0	0	0	0	0	(279)	2
3	Housekeeping	0	0	59	0	0	0	0	0	0	0	0	59	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,289	0	0	0	0	0	0	0	0	1,289	5
6	Maintenance	0	0	366	0	0	0	0	0	0	0	0	366	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	1,745	(310)	0	0	0	0	0	0	0	1,435	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(478)	0	0	0	0	0	0	0	(478)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	(478)	0	0	0	0	0	0	0	(478)	16
	C. General Administration													
17	Administrative	0	0	(90,195)	0	0	0	0	0	0	0	0	(90,195)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,500)	1,951	13,653	0	6,245	0	0	0	0	0	0	20,349	19
20	Fees, Subscriptions & Promotions	(206)	0	65	0	0	0	0	0	0	0	0	(141)	20
21	Clerical & General Office Expenses	0	0	50,166	0	0	0	0	0	0	0	0	50,166	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	54	0	0	0	0	0	0	0	0	54	24
25	Other Admin. Staff Transportation	0	0	184	0	0	0	0	0	0	0	0	184	25
26	Insurance-Prop.Liab.Malpractice	0	0	872	0	0	0	0	0	0	0	0	872	26
27	Other (specify):*	0	0	9,480	0	0	0	0	0	0	0	0	9,480	27
28	**TOTAL General Administration**	(1,706)	1,951	(15,721)	0	6,245	0	0	0	0	0	0	(9,231)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,706)	1,951	(13,976)	(788)	6,245	0	0	0	0	0	0	(8,274)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oregon Healthcare Center # 0037838 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	7,213	32,028	2,461	0	0	0	0	0	0	0	0	41,702	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,325)	40,730	811	0	47,689	0	0	0	0	0	0	73,905	32
33	Real Estate Taxes	0	3,500	2,710	0	0	0	0	0	0	0	0	6,210	33
34	Rent-Facility & Grounds	0	(341,640)	0	0	0	0	0	0	0	0	0	(341,640)	34
35	Rent-Equipment & Vehicles	0	0	965	0	0	0	0	0	0	0	0	965	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,112)	(265,382)	6,947	0	47,689	0	0	0	0	0	0	(218,858)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(34,292)	3,377	0	0	0	0	0	0	0	0	0	(30,915)	43
44	**TOTAL Special Cost Centers**	(34,292)	3,377	0	0	0	0	0	0	0	0	0	(30,915)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(44,110)	(260,054)	(7,029)	(788)	53,934	0	0	0	0	0	0	(258,047)	45

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule 6A		See Attached Schedule 6B		See Attached Schedule 6B		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	19	Professional Fees		Oregon Associates	100.00%	1,951	1,951	2
3	V	30	Depreciation		Oregon Associates	100.00%	32,028	32,028	3
4	V	32	Interest		Oregon Associates	100.00%	115,060	115,060	4
5	V	32	Interest Income-Intercompany	77,766	Oregon Associates	100.00%		(77,766)	5
6	V	32	Amortization-Mortgage Costs		Oregon Associates	100.00%	3,436	3,436	6
7	V	33	Real Estate Tax		Oregon Associates	100.00%	3,500	3,500	7
8	V	34	Rent	341,640	Oregon Associates	100.00%		(341,640)	8
9	V	43	Other		Oregon Associates	100.00%	3,377	3,377	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 419,406			$ 159,352	$ * (260,054)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$	S.W. Management Co.	100.00%	$ 31	$ 31	15
16	V	3	Housekeeping		S.W. Management Co.	100.00%	59	59	16
17	V	5	Utilities		S.W. Management Co.	100.00%	1,289	1,289	17
18	V	6	Maintenance		S.W. Management Co.	100.00%	366	366	18
19	V	17	Administrative - Salaries	145,550	S.W. Management Co.	100.00%	55,355	(90,195)	19
20	V	19	Professional Services		S.W. Management Co.	100.00%	13,653	13,653	20
21	V	20	Dues, Fees, Subs & Promotions		S.W. Management Co.	100.00%	65	65	21
22	V	21	Clerical -Salaries		S.W. Management Co.	100.00%	46,337	46,337	22
23	V	21	Clerical & General Office Exp.		S.W. Management Co.	100.00%	3,829	3,829	23
24	V	24	Travel and Seminar		S.W. Management Co.	100.00%	54	54	24
25	V	25	Other Admin. Staff Transport.		S.W. Management Co.	100.00%	184	184	25
26	V	26	Insurance-Prop, Liab & Malp.		S.W. Management Co.	100.00%	872	872	26
27	V	27	Mgmt. Allocation of Benefits		S.W. Management Co.	100.00%	9,480	9,480	27
28	V	30	Depreciation		S.W. Management Co.	100.00%	2,461	2,461	28
29	V	32	Interest		S.W. Management Co.	100.00%	811	811	29
30	V	33	Real Estate Taxes		S.W. Management Co.	100.00%	2,710	2,710	30
31	V	35	Rent-Equipment & Vehicles		S.W. Management Co.	100.00%	965	965	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 145,550			$ 138,521	$ * (7,029)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Food	$ 4,062	S & E Medical Supply Co.	100.00%	$ 3,752	$ (310)	15
16	V	3	Housekeeping	1,133	S & E Medical Supply Co.	100.00%	1,133		16
17	V	10	Medical Supplies	2,105	S & E Medical Supply Co.	100.00%	1,627	(478)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 7,300			$ 6,512	$ * (788)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional Fees	$	SFO Associates	0.00%	$ 6,245	$ 6,245	15
16	V	32	Interest - Bonds	114,595	SFO Associates	0.00%	108,118	(6,477)	16
17	V	32	Interest - Intercompany		SFO Associates	0.00%	54,166	54,166	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 114,595			$ 168,529	$ * 53,934	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Oregon Healthcare Center
0037838
12/31/2004

Schedule 6B

VII Related Parties - Page 6

Related Nursing Homes	City
In-State:	
Cahokia Nursing and Rehab	Cahokia
Caseyville Nursing and Rehab	Caseyville
Franklin Grove Nursing Center	Franklin Grove
Kenwood Healthcare Center	Chicago
Oregon Healthcare Center	Oregon
Shabbona Healthcare Center	Shabbona
Tower Hill Healthcare Center	South Elgin
Virgil Calvert Nursing and Rehab	East St. Louis
Out-of-State:	
St. Elizabeth Healthcare Center	Florissant, MO

Other Related Business Entities		
S.W. Management Co.	Skokie	Bookkeeping/Management Company
S&E Medical Supply Co.	Skokie	Medical Supplies
* SFO Associates	Skokie	Finance Company
** Unity Hospice	Skokie	Hospice Services

* This entity only relates to Shabbona Healthcare Center, Franklin Grove Nursing Center, and Oregon Healthcare Center.

** Pages 6 and 8 are not required for this entity since there was no payment from the nursing homes to the related entity.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Sheldon Wolfe	President	Administrative	31.74	See Schedule 7A	3	7.50	Salary	$ 55,355	L17,C7	1
2	Ronnie Klein	COO	Administrative	15.87	See Schedule 7B	3.5	8.75	Salary&Fees	65,452	17,3 & 21,7	2
3	Moshe Herman	CFO	Administrative	2.40	See Schedule 7C	2.8	7.00	Salary	11,491	L21,C7	3
4											4
5											5
6		NOTE: All individuals work an excess of 40 hours per week.									6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 132,298		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Oregon Healthcare Center
0037838
12/31/2004
Sheldon Wolfe **Schedule 7A**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	3	$ 55,355		$ 55,355
Caseyville Nursing and Rehab	3	55,355		55,355
Franklin Grove Nursing Center	3	55,355		55,355
Kenwood Healthcare Center	12	221,421		221,421
Oregon Healthcare Center	3	55,355		55,355
Shabbona Healthcare Center	4	73,807		73,807
Tower Hill Healthcare Center	4	73,807		73,807
Virgil Calvert Nursing and Rehab	3	55,355		55,355
St. Elizabeth Healthcare Center	1	18,452		18,452
Other	4	73,807		73,807
	40	$ 738,071		$ 738,071

SEE ACCOUNTANTS' COMPILATION REPORT

Oregon Healthcare Center
0037838
12/31/2004
Ronnie Klein **Schedule 7B**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	3.5	$ 5,452	$ 60,000	$ 65,452
Caseyville Nursing and Rehab	3.5	5,452	60,000	65,452
Franklin Grove Nursing Center	5	7,788	90,000	97,788
Kenwood Healthcare Center	20	31,154	210,000	241,154
Oregon Healthcare Center	3.5	5,452	60,000	65,452
Shabbona Healthcare Center	0	-		-
Tower Hill Healthcare Center	0	-		-
Virgil Calvert Nursing and Rehab	4	6,231	60,000	66,231
St. Elizabeth Healthcare Center	0.5	779		779
Other	0	-		-
	40	$ 62,307	$ 540,000	$ 602,307

SEE ACCOUNTANTS' COMPILATION REPORT

Oregon Healthcare Center
0037838
12/31/2004
Moshe Herman **Schedule 7C**

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

	Weighted Average Hours Worked	Salary from S.W. Management	Fees from Facility	Total Compensation
Cahokia Nursing and Rehab	4.2	$ 17,237		$ 17,237
Caseyville Nursing and Rehab	4.2	17,237		17,237
Franklin Grove Nursing Center	3.4	13,954		13,954
Kenwood Healthcare Center	8.8	36,115		36,115
Oregon Healthcare Center	2.8	11,491		11,491
Shabbona Healthcare Center	2.5	10,260		10,260
Tower Hill Healthcare Center	5.7	23,393		23,393
Virgil Calvert Nursing and Rehab	4.2	17,237		17,237
St. Elizabeth Healthcare Center	4.2	17,237		17,237
Other	0	-		-
	40	$ 164,160		$ 164,160

SEE ACCOUNTANTS' COMPILATION REPORT

s

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SW Management Co.
Street Address: 7434 N. Skokie Blvd.
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Bed Days Available	527,040	9	$ 429	$	38,064	$ 31	1
2	3	Housekeeping	Bed Days Available	527,040	9	820		38,064	59	2
3	5	Utilities	Bed Days Available	527,040	9	17,851		38,064	1,289	3
4	6	Maintenance	Bed Days Available	527,040	9	5,071		38,064	366	4
5	19	Professional Fees	Bed Days Available	527,040	9	189,030		38,064	13,653	5
6	20	Dues, Fees, Subs & Promotions	Bed Days Available	527,040	9	900		38,064	65	6
7	21	Clerical - Salaries	Bed Days Available	527,040	9	566,095	566,095	38,064	40,885	7
8	21	Clerical & General Office Exp.	Bed Days Available	527,040	9	53,022		38,064	3,829	8
9	24	Travel and Seminar	Bed Days Available	527,040	9	751		38,064	54	9
10	25	Other Admin. Staff Transport.	Bed Days Available	527,040	9	2,548		38,064	184	10
11	26	Insurance-Prop, Liab & Malp.	Bed Days Available	527,040	9	12,072		38,064	872	11
12	27	Mgmt. Allocation of Benefits	Bed Days Available	527,040	9	131,259		38,064	9,480	12
13	32	Interest	Bed Days Available	527,040	9	11,228		38,064	811	13
14	33	Real Estate Taxes	Bed Days Available	527,040	9	37,528		38,064	2,710	14
15	35	Rent-Equipment & Vehicles	Bed Days Available	527,040	9	13,358		38,064	965	15
16										16
17	17	Administrative - Salaries	Avg. Hours Worked	40	9	738,071	738,071	3	55,355	17
18	21	Clerical - Salaries	Avg. Hours Worked	40	7	62,307	62,307	4	5,452	18
19										19
20	30	Depreciation	Direct Cost						2,461	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,842,340	$ 1,366,473		$ 138,521	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S & E Medical Supply Co.
Street Address: 7434 N. Skokie Blvd.
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-9300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Direct Costs			$	$		$ 3,752	1
2	3	Housekeeping	Direct Costs						1,133	2
3	10	Medical Supplies	Direct Costs						1,627	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 6,512	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SFO Associates
Street Address: 7434 N. Skokie Blvd.
City / State / Zip Code: Skokie, IL 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Note Receivable	6,500,000	3	$ 20,295	$	2,000,000	$ 6,245	1
2	32	Interest - Bonds	Note Receivable	6,500,000	3	351,383		2,000,000	108,118	2
3										3
4	32	Interest - Intercompany	Direct Cost						54,166	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 371,678	$		$ 168,529	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Oregon Associates	X		Bonds		07/01/04	$ 2,000,000	$ 1,261,537	08/15/14	0.0665	$ 108,118	1
2	(Loan Payable-SFO Assoc.)	X										2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,000,000	$ 1,261,537			$ 108,118	9
	B. Non-Facility Related*											
10	Allocated from SW Mgmt. - Mortgage										811	10
11	Amortization of loan costs										3,436	11
12	Interest income offset, net of intercompany interest										(14,861)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (10,614)	14
15	TOTALS (line 9+line14)						$ 2,000,000	$ 1,261,537			$ 97,504	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.		$ 31,285	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 30,145	2
3. Under or (over) accrual (line 2 minus line 1).		$ (1,140)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 30,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county	Appraisal Fee	$ 3,500	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.	Home office allocation	2,710	
TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 35,570	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	26,806	8
	2000	28,528	9
	2001	29,404	10
	2002	29,795	11
	2003	30,145	12

Accrual = Prior year real estate tax 30,145 x 1.01 = 30,466

Use 30,500

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oregon Healthcare Center COUNTY Ogle

FACILITY IDPH LICENSE NUMBER 0037838

CONTACT PERSON REGARDING THIS REPORT Sheldon Wolfe

TELEPHONE (847) 982-2300 FAX #: (847) 982-2304

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-04-476-009	Long-term care property	$ 30,145.06	$ 30,145.06
2.	10-28-412-049-0000	SW Management allocation	$ 38,969.77	$ 2,710.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 69,114.83	$ 32,855.06

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,900 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care		1992	$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	104		1992		$ 1,008,880	$	40	$ 25,222	$ 25,222	$ 323,682	4
5											5
6	SW Mgmt.		1995		31,260		39	893	893	8,623	6
7	Allocation										7
8											8
	Improvement Type**										
9	Various			1992	6,160		20	-		6,160	9
10	Various			1993	26,517	320	20	1,325	1,005	15,518	10
11	Various			1994	5,324		20	266	266	3,046	11
12	Various			1995	3,498		20	175	175	1,677	12
13	Various			1996	2,042	52	20	102	50	849	13
14	Various			1997	2,880		20	144	144	1,092	14
15	Various			1998	65,055	933	20	3,253	2,320	23,298	15
16	Various			1999	36,058	741	20	1,803	1,062	10,443	16
17											17
18	Model 10Kpa Code A/R			2001	1,189		20	59	59	203	18
19	Generator Repair			2001	1,010		20	50	50	160	19
20	Motor			2001	783		20	39	39	143	20
21	Glass Thermo Unit			2001	868		20	43	43	152	21
22	Install Board			2001	816		20	41	41	137	22
23	Gas Controller			2001	739		20	37	37	120	23
24	Clutch & Output Brd			2001	1,138		20	57	57	185	24
25	Vinyl Flooring			2001	912		20	46	46	179	25
26											26
27	Air Conditioners			2002	1,470		20	74	74	368	27
28	Air Conditioners			2002	1,366		20	68	68	284	28
29	Wall-Replaced			2002	5,000	128	20	250	122	646	29
30											30
31	Roof Exhaust Fan			2003	3,128		10	313	313	469	31
32	Condensor walk - in Freezer			2003	3,193		7	456	456	608	32
33	Radiator			2003	3,473		10	347	347	434	33
34	Hot Water Repair			2003	1,610		20	80	80	107	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Nurses Station	2004	$ 15,850	$ 34	20	$ 396	$ 362	$ 396	37
38	Counter tops	2004	4,668	10	20	117	107	117	38
39	Nurses Station	2004	1,290	3	20	32	29	32	39
40	Basin	2004	7,500	64	20	188	124	188	40
41									41
42									42
43									43
44									44
45									45
46	SW Management allocation - Leasehold Improvements	1995	3,336		20	167	167	1,846	46
47	SW Management allocation - Leasehold Improvements	1996	582		20	29	29	249	47
48	SW Management allocation - Leasehold Improvements	1997	839		20	42	42	418	48
49	SW Management allocation - Leasehold Improvements	1998	577		20	29	29	195	49
50	SW Management allocation - Leasehold Improvements	1999	1,603		20	80	80	408	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,250,614	$ 2,285		$ 36,223	$ 33,938	$ 402,432	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 113,679	$ 160	$ 6,421	$ 6,261	10	$ 99,477	71
72	Current Year Purchases	11,404	303	569	266	10	569	72
73	Fully Depreciated Assets	247,015					247,015	73
74	Allocation from SW Management	8,073		802	802		6,876	74
75	TOTALS	$ 380,171	$ 463	$ 7,792	$ 7,329		$ 353,937	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	Wheelchair lift for van	2003	$ 4,635	$	$ 464	$ 464	5	$ 155	76
77	Resident care	E-350 Van	2003	26,099	4,176	3,728	(448)	5	2,796	77
78										78
79	SW Management	2004 Cadillac	2004	4,186		419	419		419	79
80	TOTALS			$ 34,920	$ 4,176	$ 4,611	$ 435		$ 3,370	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,715,705	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 6,924	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 48,626	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 41,702	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 759,739	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	N/A	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions		N/A					4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 1,045 Description: Nursing equipment - 80; SW Management allocation - 965
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A(3)	hrs	$	6,334	$ 85,507	$	6,334	$ 85,507	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		93	2,885		93	2,885	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		5,681	82,373		5,681	82,373	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				35,112		35,112	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Ambulance	39(3)				116			116	13
14	TOTAL			$	12,108	$ 170,881	$ 35,112	12,108	$ 205,993	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 280,613	$ 280,613	1
2	Cash-Patient Deposits	9,536	9,536	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	410,665	410,665	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,775	13,775	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Related Parties	115,624	1,029,419	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 830,213	$ 1,744,008	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		1,040,140	14
15	Leasehold Improvements, at Historical Cost	117,007	210,474	15
16	Equipment, at Historical Cost	258,915	415,091	16
17	Accumulated Depreciation (book methods)	(263,364)	(759,739)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Mortgage cost - net		101,460	22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 112,558	$ 1,057,426	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 942,771	$ 2,801,434	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 25,416	$ 25,416	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,401	13,401	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	55,307	55,307	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,026	8,026	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,500	30,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Expenses	53,898	53,898	36
37	Short-term Loan Exchange	28,750	28,750	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 215,298	$ 215,298	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	420,790	1,261,537	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 420,790	$ 1,261,537	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 636,088	$ 1,476,835	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 306,683	$ 1,324,599	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 942,771	$ 2,801,434	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Oregon Healthcare Center
Provider #: 0037838
01/01/04 to 12/31/04 **Schedule 17A**

XV. Balance Sheet

	Operating	After Consolidation
Line 9 - Other		
	-	-

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 396,996	1
2	Restatements (describe):		2
3			3
4	**Prior period adjustment**	158,163	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 555,159	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(48,476)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(200,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (248,476)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 306,683	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,871,748	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,871,748	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	139,562	6
7	Oxygen	4,190	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 143,752	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	8,268	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 8,268	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15,325	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,325	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Cable TV**	900	28
28a	**Miscellaneous revenue**	520	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,420	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,040,513	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	738,265	31
32	Health Care	1,152,914	32
33	General Administration	672,968	33
	B. Capital Expense		
34	Ownership	401,603	34
	C. Ancillary Expense		
35	Special Cost Centers	66,143	35
36	Provider Participation Fee	57,096	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,088,989	40
41	**Income before Income Taxes (line 30 minus line 40)****	(48,476)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (48,476)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
This entity is a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 39,518	$ 19.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,269	3,313	72,702	21.94	3
4	Licensed Practical Nurses	13,046	13,471	243,518	18.08	4
5	Nurse Aides & Orderlies	52,839	54,395	541,965	9.96	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,204	4,585	51,252	11.18	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,917	2,201	28,822	13.09	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,346	21,320	159,673	7.49	15
16	Dishwashers					16
17	Maintenance Workers	5,005	5,423	70,282	12.96	17
18	Housekeepers	15,559	16,586	128,261	7.73	18
19	Laundry	9,177	9,589	63,406	6.61	19
20	Administrator	2,000	2,080	36,116	17.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,444	7,746	128,146	16.54	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	136,806	142,789	$ 1,563,661 *	$ 10.95	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	$ 1,273	L1, C3	35
36	Medical Director	monthly	3,600	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	7,623	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	monthly	458	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 12,954		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Donna Vanmiddendrip (1/04-5/04)	Administrator	0	$ 12,112
Christina Lee (7/04-12/04)	Administrator	0	14,153
Bernita Carr (04/04-07/04)	Administrator	0	9,851
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 36,116

B. Administrative - Other

Description	Amount
SW Management - management fees	$ 145,550
Ronnie Klein - management fees	60,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 205,550
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Ashman & Stein	Legal	$ 7,519
Fearer, Nye, et.al.	Legal	4,298
Winston & Strawn	Legal	526
Smith, Hanson, et.al.	Legal	45
Frost, Ruttenberg & Rothblatt	Accounting	14,623
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 27,011

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,862
Unemployment Compensation Insurance	20,131
FICA Taxes	119,621
Employee Health Insurance	43,915
Employee Meals	3,642
Illinois Municipal Retirement Fund (IMRF)*	
Uniforms	154
Employee Morale	233
TOTAL (agree to Schedule V, line 22, col.8)	$ 221,558

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 23)	280
IL Council on Long-Term Care dues	3,744
Chamber of Commerce dues	206
Miscellaneous dues	434
Miscellaneous Licenses, Permits, etc.	631
Home office allocation	65
Less: Public Relations Expense	(206)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,154

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	597
Home office allocation	54
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 651

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Oregon Healthcare Center
Provider #: 0037838
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	27,011
Allocated from Real Estate Entity - Legal	1,951
Allocated from Management Company - Accounting	
Frost, Ruttenberg & Rothblatt	491
Allocated from Management Company - Legal	13,162
Allocated from SFO Associates - Accounting	
Frost, Ruttenberg & Rothblatt	6,245
Less: Non-allowable legal costs	(1,500)
Total (agree to Schedule V, line 19, column 8)	47,360

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3			N/A										
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Oregon Healthcare Center # 0037838 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care - 3744**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **8,031** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **57,096**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **3,642** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? ____
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

		Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary		188,495	6,372	1,273	196,140	0	196,140	0	196,140
2. Food Purchase		0	125,717	0	125,717	0	125,717	-3,921	121,796
3. Housekeeping		128,261	33,703	0	161,964	0	161,964	-7,972	153,992
4. Laundry		63,406	8,155	0	71,561	0	71,561	0	71,561
5. Heat and Other Utilities		0	0	82,070	82,070	0	82,070	1,289	83,359
6. Maintenance		70,282	26,276	4,255	100,813	0	100,813	366	101,179
7. Other (specify)*		0	0	0	0	0	0	0	0
8. Total General Services		450,444	200,223	87,598	738,265	0	738,265	-10,238	728,027
9. Medical Director		0	0	3,600	3,600	0	3,600	0	3,600
10. Nursing & Medical Records		897,703	16,155	7,623	921,481	0	921,481	7,553	929,034
10a. Therapy		0	0	171,223	171,223	0	171,223	0	171,223
11. Activities		51,252	5,358	0	56,610	0	56,610	0	56,610
12. Social Services		0	0	0	0	0	0	0	0
13. Nurse Aide Training		0	0	0	0	0	0	0	0
14. Program Transportation		0	0	0	0	0	0	0	0
15. Other (specify)*		0	0	0	0	0	0	0	0
16. Total Health Care & Programs		948,955	21,513	182,446	1,152,914	0	1,152,914	7,553	1,160,467
17. Administrative		36,116	0	205,550	241,666	0	241,666	-90,195	151,471
18. Directors Fees		0	0	0	0	0	0	0	0
19. Professional Services		0	0	27,011	27,011	0	27,011	20,349	47,360
20. Fees, Subscriptions & Promotion		0	0	5,295	5,295	0	5,295	-141	5,154
21. Clerical & General Office		128,146	0	34,343	162,489	0	162,489	50,166	212,655
22. Employee Benefits & Payroll		0	0	217,916	217,916	0	217,916	3,642	221,558
23. Inservice Training & Education		0	0	0	0	0	0	0	0
24. Travel and Seminar		0	0	597	597	0	597	54	651
25. Other Admin. Staff Trans		0	0	5,947	5,947	0	5,947	184	6,131
26. Insurance-Prop.Liab.Malpractice		0	0	12,047	12,047	0	12,047	872	12,919
27. Other (specify)*		0	0	0	0	0	0	9,480	9,480
28. Total General Adminis		164,262	0	508,706	672,968	0	672,968	-5,589	667,379
29. Total General Administrative		1,563,661	221,736	778,750	2,564,147	0	2,564,147	-8,274	2,555,873
30. Depreciation		0	0	6,924	6,924	0	6,924	41,702	48,626
31. Amortization of Pre-Op. & Org.		0	0	0	0	0	0	0	0
32. Interest		0	0	23,599	23,599	0	23,599	73,905	97,504
33. Real Estate		0	0	29,360	29,360	0	29,360	6,210	35,570
34. Rent - Facility & Grounds		0	0	341,640	341,640	0	341,640	-341,640	0
35. Rent - Equipment & Vehicles		0	0	80	80	0	80	965	1,045
36. Other (specify):*		0	0	0	0	0	0	0	0
37. Total Ownership		0	0	401,603	401,603	0	401,603	-218,858	182,745
38. Medically Necessary T		0	0	0	0	0	0	0	0
39. Ancillary Service Cent		0	35,112	116	35,228	0	35,228	0	35,228
40. Barber and Beauty Shop		0	0	0	0	0	0	0	0
41. Coffee and Gift Shops		0	0	0	0	0	0	0	0
	42	0	0	57,096	57,096	0	57,096	0	57,096
43. Other (specify):*		0	0	30,915	30,915	0	30,915	-30,915	0
44. Total Special Cost Ce		0	35,112	88,127	123,239	0	123,239	-30,915	92,324
45. Grand Total		1,563,661	256,848	1,268,480	3,088,989	0	3,088,989	-258,047	2,830,942

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	280,613	280,613
2. Cash - Patient Deposits	9,536	9,536
3. Accounts & Notes Recievable	410,665	410,665
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	13,775	13,775
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	115,624	1,029,419
10. Total current assets	830,213	1,744,008
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	50,000
14. Buildings, at Historical Cost	0	1,040,140
15. Leasehold Improvements, Historical Cost	117,007	210,474
16. Equipment, at Historical Cost	258,915	415,091
17. Accumulated Depreciation (book methods)	-263,364	-759,739
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	101,460
23. other (specify):	0	0
24. Total Long-Term Assets	112,558	1,057,426
25. Total Assets	942,771	2,801,434
CURRENT LIABILITIES		
26. Accounts Payable	25,416	25,416
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	13,401	13,401
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	55,307	55,307
31. Accrued Taxes Payable	8,026	8,026
32. Accrued Real Estate Taxes	30,500	30,500
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	53,898	53,898
37. Other Current Liabilities (specify):	28,750	28,750
38. Total Current Liabilities	215,298	215,298
LONG TERM LIABILITES		
39.Long-Term Notes Payable	420,790	1,261,537
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	420,790	1,261,537
46.Total Liabilities	636,088	1,476,835
47.Total Equity	306,683	1,324,599
48.Total Liabilities and Equity	942,771	2,801,434

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,871,748
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	2,871,748
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	139,562
7. Oxygen	4,190
Subtotal - Anciliary Revenue	143,752
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	8,268
22. Laundry	0
Subtotal - Other Operating Revenue	8,268
24. Contributions	0
25. Interest and Other Investments Income	15,325
Subtotal - Non-Operating Revenue	15,325
27. Other Revenue (specify):	1,420
28. Other Revenue (specify):	0
Subtotal - Other Revenue	1,420
30. Total Revenue	3,040,513
31. General Services	738,265
32. Health Care	1,152,914
33. General Administration	672,968
34. Ownership	401,603
35. Special Cost Centers	66,143
35. Provider Participation Fee	57,096
37. Other	0
40. Total Expenses	3,088,989
41. Income Before Income Taxes	-48,476
42. Income Taxes	0
43. Net Income or Loss for the Year	-48,476